Supreme Court, U.S.
FILED
JUL 1 1997
CLERK

No. 96-1806

In the

Supreme Court of the United States

October Term, 1996

THE MARYLAND PSYCHIATRIC SOCIETY, INC.,
Petitioner,

v.

MARTIN P. WASSERMAN, M.D., J.D., *et al.*,
Respondents.

On Petition For A Writ Of Certiorari To The United States Court of Appeals for the Fourth Circuit

BRIEF OF RESPONDENT WASSERMAN IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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July 14, 1997 **Counsel of Record*

QUESTION PRESENTED

Do the Medicare and Medicaid statutes creating the federal Qualified Medicare Beneficiary (QMB) program require the State of Maryland to pay the portion of psychiatrists' fees for out-patient services to QMB participants that the Medicare statute excludes from coverage?

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STATEMENT OF THE CASE

This case involves a hybrid Medicare/Medicaid program called the "qualified Medicare beneficiary" or "QMB" program, under which states use their Medicaid funds to pay the cost-sharing requirements for both Medicaid-eligible individuals and some individuals who are not otherwise eligible for Medicaid. The Petitioner is a group of psychiatrists who seek to require the State of Maryland to reimburse them for a higher percentage of their fees than they have been receiving for their services to a QMBs. The issue is whether Congress stated explicitly in

the enabling legislation that States are required to pay on behalf of QMBs that part of a psychiatrist's fee that the Medicare statute excludes from Medicare reimbursement.

A. Relevant Medicare Provisions

The State of Maryland participates in the federal Medicare program. Under Part B of the Medicare program, the federal government provides health care insurance for outpatient care of eligible participants, pursuant to Title XVIII of the Social Security Act of 1965, Part B. *See* 42 U.S.C. §§ 1395j-1395w-4. Health care providers choosing to participate in the Medicare program are reimbursed by the federal government according to a fee schedule adopted by the U. S. Department of Health and Human Services ("HHS"). *See* 42 U.S.C. §1395w-4(a), (b). The amount of the federal government's reimbursement ordinarily is 80% of the fee schedule amount for that service. 42 U.S.C. §1395*l*(a).

Persons covered by the insurance program, called "beneficiaries," are required to pay for some of the medical fees themselves. For most services, these "cost-sharing" payments consist of premiums, deductibles, and "coinsurance." 42 U.S.C. §§ 1395r (premiums), 1395cc (coinsurance); 42 C.F.R. §410.160 (deductibles). In addition, the Medicare statute excludes from coverage a portion of a provider's fee for out-patient psychiatric services ("the mental health services exclusion"). 42 U.S.C. §1395*l*(c). This exclusion is one of several included in the original Medicare statute. *See* S. Rep. No. 404, 89th Cong., 1st Sess. (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 1989-90, 1983 (no reimbursement for routine eye care and hearing exams, dental care, or orthopedic shoes; and a "special limitation on benefits" for outpatient treatment of mental, psychoneurotic, and personality disorders).

As a result of this exclusion, Medicare's 80% payment is calculated not on the fee schedule amount for outpatient mental health services, but on an "allowed amount" of 62.5% of the fee schedule amount. Thus, Medicare pays

psychiatrists and other mental health professionals only 80% of 62.5% of the fee schedule amount for outpatient mental health services to Medicare beneficiaries. 42 U.S.C. §§1395k, 1395*l*(c). The providers may attempt to recover the excluded amount from the patient, or forego payment of it. 42 U.S.C. §1395cc(a)(2). This mental health services exclusion has been retained in all of the various amendments to the Medicare statute made since 1965. *See* 42 U.S.C. 1395*l*(c); 135 Cong. Rec. H9333-01, H9551 (November 21, 1989).

B. Relevant Medicaid Provisions

Maryland also participates in the federal Medicaid program. In this program, Title XIX of the Social Security Act of 1965, the federal government shares with States the cost of paying for medical care for persons with annual incomes below a certain level. 42 U.S.C. §§1396 - 1396v. Under this program, the State receives federal Medicaid funds, which it combines with State funds to reimburse participating health care providers for their services to eligible individuals. Providers who agree to participate in the Medicaid program are reimbursed according to a rate schedule adopted by the State. *See Rehabilitation Ass'n of Va. v. Kozlowski*, 42 F.3d 1444, 1447 (4th Cir. 1994), *cert. denied*, 116 S.Ct. 60 (1955).

C. The QMB Program

In order to participate in the federal Medicaid program, the State must agree to also participate in a hybrid Medicare/Medicaid program called the "qualified Medicare beneficiary" or "QMB" program. 42 U.S.C. §1396a(a)(10)(E). "Qualified Medicare beneficiaries" or "QMBs" are individuals who either are eligible for both the Medicare and Medicaid programs or are eligible for Medicare and not Medicaid, but meet certain income criteria. *See Rehabilitation Ass'n*, 42 F.3d at 1447. Under the QMB program, the State uses its Medicaid funds to pay the "cost-sharing" amounts that the QMBs would otherwise be required to assume under the Medicare program. 42

U.S.C. §1396a(a)(10)(E)(i) . The statute defines "cost-sharing" as consisting of four types of beneficiary payments: premiums; deductibles; "coinsurance"; and the 20% of the allowed amount of the provider's fee left uncovered after Medicare's 80% payment of the allowed amount. 42 U.S.C. §1396d(p(3). "Coinsurance" is not defined in either the Medicare or the Medicaid statute.

D. The History of the Case

At issue in this case is whether the Medicare mental health services exclusion is included in the "cost-sharing" amounts that Maryland is required to pay on behalf of QMBs under the QMB program. The Medicaid statute provisions creating the QMB program are silent as to how the QMB program is to treat the Medicare mental health services exclusion. App. 5.

Although HHS advised one State in 1989 that the mental health services exclusion should be considered part of "cost sharing" under the QMB program, App. 173-177, the State of Maryland has never paid the mental health services exclusion for QMBs. J.A. 93, 95.[1] Thus, in Maryland, providers taking on QMB patients have always known that neither the State nor the federal government reimburses providers for 37.5% of the fee schedule amount for outpatient mental health services to QMBs. App. 5. In 1992, HHS revised its interpretation of the provision, adopting the position that Maryland has always taken. App. 166-172.

In March of 1995, the Petitioner, an association of psychiatrists, filed suit against Martin P. Wasserman, the Secretary of the Maryland's Department of Health and Mental Hygiene, and Donna E. Shalala, the Secretary of

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[1] "J.A." refers to the Joint Appendix filed in the Fourth Circuit appeal. Petitioner's Appendix does not include the affidavit that is part of the record in the district court and included the Joint Appendix below.

HHS. The suit requested a declaratory judgment that the mental health services exclusion is part of "cost sharing" for QMBs, and sought an order requiring the Maryland Medicaid program to pay the psychiatrists for this exclusion. App. 155-158.

No trial was held in the case. The district court found that there was no genuine dispute of material fact and ruled in favor of the psychiatrists on cross-motions for summary judgment. App. 46-47. The district court based its decision on a finding that the "ordinary" meaning of the word "coinsurance" includes the mental health services exclusion. App. 56-57. The court found support for its decision in Medicare case law holding that, in general, Medicare providers are entitled to receive full reimbursement of the fee schedule amount for their services,[2] and in QMB cases prohibiting States from limiting their QMB reimbursement to their Medicaid reimbursement rates. App. 64-66.

The Fourth Circuit reversed the district court, finding that:

> If Congress intended states to pay the 37.5% exclusion for outpatient psychiatric services for QMBs, it certainly did not do so explicitly, clearly, and unambiguously.

App. 9. The Fourth Circuit held that the district court's ruling requires a conclusion that the exclusion "is implicitly included" in the statute's "coinsurance" provisions. App. 7. "Such a reading of 'coinsurance' violates the boundaries of federal power set forth in *Pennhurst v. Halderman*, 451 U.S. 1 (1981), and finds no basis in the Medicare/Medicaid statutes." App. 8. The Fourth Circuit subsequently denied the Society's petition for rehearing. App. 24.

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[2] The cases use the term "reasonable charge." However, since 1992, the Medicare statute has used a "fee schedule" instead of "reasonable charges." *See* 42 U.S.C. §1395w-4(a), (b).

REASONS FOR DENYING THE WRIT

Certiorari is not warranted in this case because the Fourth Circuit's decision is the only appellate case to address the specific issue that the Petitioner raises. Thus, the decision below does not conflict with any other federal appellate ruling, and there is no confusion among the lower courts that needs this Court's clarification. Moreover, the decision below is firmly grounded in established case law, and raises no new substantial federal question. The court correctly held that, because neither the statutory provisions nor the legislative history clearly says that the State must pay the higher rate, the federal courts cannot now impose that financial burden upon the State of Maryland. Simply put, this case does not present any reason for this Court to exercise its discretionary jurisdiction.

A. There Is No Conflict Among The Circuits.

The petition should be denied principally because no federal appellate court other than the Fourth Circuit has addressed the issue raised in this case. No conflict exists among the federal courts of appeals, since the federal appellate cases relied upon by Petitioner involve an altogether different issue from that raised here.

In the appellate cases cited in the Petition, *see* Petition at 16, the courts considered whether States may "cap" their QMB reimbursements at the State's Medicaid rate for those services. *See New York City Health & Hospitals Corp. v. Perales*, 954 F.2d 854 (2d Cir.), *cert. denied*, 506 U.S. 972 (1992); *Pennsylvania Medical Society v. Snider*, 29 F.3d 886 (3d Cir. 1994); *Haynes Ambulance Service, Inc. v. State of Alabama*, 36 F.3d 1074 (11th Cir. 1994). None of these cases involves or addresses the QMB program's treatment of the Medicare mental health services exclusion.

In reaching the decision that States cannot limit QMB reimbursement to Medicaid rates, the courts in the cases cited reasoned that States must pay the "full" difference

between the federal Medicare payment of 80% and the fee schedule amount. This language was used to clarify that the States may not limit what they pay to the Medicaid reimbursement rate, which typically is much less than the Medicare fee schedule amount. *See, e.g., Rehabilitation Ass'n.*, 42 F.3d at 1447. In addition, the cases rely in part upon a Medicare principle that providers are entitled to 100% of their reasonable charges for Medicare-covered services. *See New York City Health & Hospitals Corp. v. Perales*, 954 F.2d 854, 858 (2d Cir.), *cert. denied*, 596 U.S. 972 (1992); *Pennsylvania Medical Society v. Snider*, 29 F.3d 886, 891 (3d Cir. 1994); *Haynes Ambulance Service, Inc. v. State of Alabama*, 36 F.3d 1074 (11th Cir. 1994) (adopting the reasoning of *Snider* without discussion).[3] However, none of these cases addresses whether and how this principle would be applied to a service excluded from Medicare coverage.

The Fourth Circuit has declined to adopt the broad principle that providers are always entitled to their full fee schedule amount, noting that the statute "authorizes providers to *charge* for the full amount of provided services," but "does not guarantee full *recovery*." App. 20 (emphasis added). However, the court has held that States may not cap their QMB reimbursement at their Medicaid rates. *See Rehabilitation Ass'n of Virginia, Inc. v. Kozlowski*, 42 F.3d 1444, 1459 (1994). The court did not revisit this ruling in this appeal. Therefore, the Fourth Circuit is in agreement with the cases which Petitioner erroneously asserts conflict with the decision in this case.

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[3] *Stephenson v. Shalala*, 87 F.3d 350, 352 (9th Cir. 1996), also cited in the Petition at 17, involves a different issue. There, beneficiaries claimed that hospitals were charging them more than 20% of the hospital's costs. However, the *dicta* cited by Petitioner states that providers are entitled to 100% of their "Medicare-*allowed* costs." In the case at bar, the exclusion is not a Medicare-allowed cost.

Petitioner also cites an unpublished district court case apparently holding that the State of Washington is required to pay the Medicare mental health services exclusion for QMBs. *See South Sound Radiologists, Inc. v. Soliz*, No. C95-1218WD (Jan. 8, 1996), App. 79. However, that case was decided before the Fourth Circuit's decision in this case. In the only district court decision on this issue published since the Fourth Circuit's ruling in this case, the District Court for the Northern District of California followed the Fourth Circuit's opinion in this case, holding that the State is not required to reimburse providers for the 37.5% mental health services exclusion for QMBs. *Dameron Physicians Medical Group, Inc. v. Shalala*, 961 F.Supp. 1326, 1334 (1997). Thus, there is no conflict between the Fourth Circuit and courts in other circuits.

B. The Petition Does Not Present A Substantial Federal Question

Further review of this case is also unwarranted because the decision below rests upon a legal determination that conforms with prior decisions of this Court. It is a well-established principle of federalism that, in order to impose an obligation upon the States, a federal funding statute must do so clearly and unambiguously. *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981). The appellate court below correctly found that the QMB provisions of the Medicaid statute do not clearly and unambiguously require the State to pay the Medicare mental health services exclusion on behalf of QMBs. In the absence of such clarity, a federal funding statute may not be held to impose an obligation upon a State. The decision below is in full accord with this rule. Thus, the decision resolved no novel or unsettled question of federal law and gives rise to no error that justifies the exercise of this Court's discretionary jurisdiction.

In *Pennhurst*, this Court considered whether the "findings" section of the Developmentally Disabled Assistance and Bill of Rights Act created substantive rights

enforceable in an action by a private individual. Recognizing that the enactment is a typical federal funding statute, the Court held that principles of federalism require that, "if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously." 451 U.S. at 17. The Court ruled that the "findings" section of the statute did not clearly and unambiguously impose a condition on the grant of the federal funds. 451 U.S. at 19.

Following this general principle of *Pennhurst*, the appellate court below found that no provision of the Medicaid or Medicare statutes, including the QMB provisions, addresses coverage of the mental health services exclusion for QMBs. App. 14. Therefore, no provision clearly and unambiguously imposes on the State a requirement of paying the mental health services exclusion in order to receive federal funds. Thus, the decision explicitly and correctly follows this Court's *Pennhurst* rule.

Citing the discussion in *Pennhurst* regarding "precatory," as opposed to "mandatory," language, 451 U.S. at 18, the Petitioner argues that *Pennhurst* does not govern the outcome here. Petition at 20-24 (also citing *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498 (1980). However, in applying *Pennhurst* to the Medicare mental health services exclusion, the Petition mistakenly focuses upon the Medicaid provisions that require States to adopt the entire QMB program in order to participate in the Medicaid program. *See* Petition at 21-22. In determining whether a statute imposes a condition on the receipt of federal funds, the court looks at the specific provision at issue, not the entire legislative scheme. *See Pennhurst*, 451 U.S. at 12-13 (while other sections of the statute create explicit conditions on receipt of federal funds, the findings provision, 42 U.S.C. §6010, does not).[4] It is undisputed that the Medicaid

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[4] "The existence of explicit conditions throughout the Act, and the absence of conditional language in § 6010 [the "findings"

statute requires the State to create a QMB program. *See* Petition at 21-22, citing Medicaid provisions. However, this "mandatory" language does not require the State's QMB program to specifically include coverage of the mental health services exclusion. That is the ambiguity that *Pennhurst* says must be resolved in favor of the State.

The appellate court's reading of *Pennhurst* on this issue is reinforced by the nature of the cases cited by the Petitioner in support of its argument on this point. *See* Petition at 19. In none of those cases was there a closely related statute explicitly excluding the program at issue from coverage. *See Wright v. Roanoke Redev. & Housing Auth.*, 479 U.S. 418 (1987) (addressing availability of a private cause of action under the statute in question); *Bennett v. Kentucky Dept. of Educ.*, 470 U.S. 656 (1985) and *Bell v. New Jersey*, 461 U.S. 773 (1983) (actions by the federal administering agency to recover federal funds, involving issues of interpretation of statutory provisions that both parties agreed were conditions on funding); *School Board of Nassau County, Florida v. Arline*, 480 U.S. 273, n. 15 (1987) (*Pennhurst* does not require ignoring ordinary rules of statutory construction).

The Petition also misstates some of the very facts that demonstrate that the federalism principles of *Pennhurst* govern this case. Appendix H to the Petition is a 1994 letter from the Petitioner to a Maryland official that implies that, in 1993, Maryland stopped reimbursing psychiatrists for the mental health services exclusion for QMBs. App. 159-162. Although this letter is labeled in the Petition as a "Trial Exhibit," Petition at *v*, there was no trial in the case; and the letter was never sworn or attached to the Petitioner's motion for summary judgment. Rather, it was attached to the unsworn complaint. J.A. 28-29.

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section], manifest the limited meaning of § 6010." *Pennhurst*, 451 U.S. at 23.

In contrast, the State filed with its motion for summary judgment in the district court an affidavit from the administrator of the State's QMB reimbursement program which includes the following sworn statement:

> 6. The State Medical Assistance Program ["MAP"] has never reimbursed providers of outpatient psychiatric services to QMBs for any amount over 20% of the Medicare allowed rate. Even before the June 11, 1992 memorandum from HCFA confirming that the reimbursement amount for these services need not be more than 20% of the allowed amount, Maryland's MAP provided for reimbursement at that rate. Maryland's use of that reimbursement rate has never been challenged or disapproved by HCFA.

J.A. 95. Thus, before the district court decision in this case, Maryland had never reimbursed providers of out-patient mental health services to QMBs for the Medicare mental health services exclusion. *See* appellate opinion, App. 5. The Fourth Circuit accurately and aptly characterized the district court's order as an "ambush" of the State's treasury. App. 16.

Contrary to the Petitioner's assertion, *see* Petition at 27-30, the appellate court also applied well-established rules of statutory construction along with the *Pennhurst* federalism rule to interpret the Medicaid and Medicare provisions at issue here. Thus, the court correctly ruled that the "general dictionary definition" of "coinsurance" was "too loose to support the imposition of substantial financial burdens on state governments." App. 10-12. The court also followed the undisputed principle of statutory construction that one provision of a statute may not be construed "in a way that renders another provision of the same enactment superfluous." App. 11. Thus, the court properly ruled that

the Petitioner's interpretation of the provision could not be correct, and adopted the only construction that permits a consistent reading of the term "coinsurance" as it is used throughout the statute. App. 12.[5]

Also in accordance with accepted statutory construction rules, the court correctly considered the legislative intent underlying the statutes. The court noted that Congress had made a "judgment that mental health services have a lesser claim than physical health services on scarce government resources." App. 21. The court wisely opined that "[i]t would be ironic to conclude that when Congress designates a particular service for lesser funding it expects states to spend a greater percentage of their limited Medicaid funds on that disfavored service." App. 21-22.

The decision below is wholly in accord with both established principles of statutory construction and this Court's principles of federalism as enunciated in *Pennhurst*. The petition should be denied because that decision states no new rule of federal law, and reveals no ambiguity in existing principles of federalism or statutory construction.

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[5] Contrary to the Petitioner's assertions, there is no "plain language" in the statutory provision at issue; Petition at 28; nor is the rule regarding surplusage one of mere "overlap" or "redundancy." *See* Petition at 28-29; App. 10-11.

CONCLUSION

For the reasons stated, the petition should be denied.

Respectfully submitted,

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